

LONG TERM CARE: A GROWING CONCERN

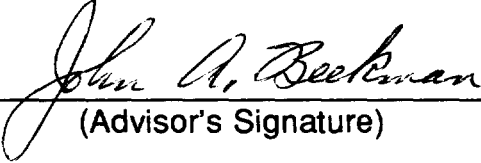
An Honors Thesis (HONRS 499)

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II. Introduction

Long term care (LTC) is the name given to the services provided for individuals who, because of chronic illnesses, disabilities, or mental deterioration cannot care for themselves and therefore need assistance with everyday activities for an extended period of time. Such assistance is often provided by nursing homes, retirement communities, adult day-care facilities, home health aids, volunteers, friends, and family.

There are three main types of care provided for the elderly: skilled nursing care, intermediate care, and custodial care. Skilled nursing care is care required by a physician and is for those who need intensive and continuous 24-hour per day care by a full-time registered nurse or medical professional. Skilled nursing care can be considered one step away from full hospital care. Intermediate care is for the elderly who require nursing assistance by a doctor's order as well. However, the people under intermediate care generally require routine supervision rather than round-the-clock attention. Custodial care is for those who require assistance with personal care and daily activities of living, but do not necessarily need health-care services [20, p.43].

Although the idea of long term care has been around for quite some time, the past twenty years have shown a growing concern about the future of long term care in this country. This concern arises from the fact that more and more people are becoming aware that "America is aging," [14, p.30]. The number of these aging people is rising faster every year, as well as the number of people requiring long term care.

III. The Growing Elderly Population and the Increased Need for LTC

America is and has been growing older for two main reasons. The first is that large numbers of people born just before and after World War II are growing older, resulting in large numbers of elderly today and in the future. This fact, combined with the steady decline in the proportion of children being born, will produce continual increases in the percentage of older people with respect to the United States population. The other main reason for the growing elderly population is that technological and medical advances have produced longer life expectancies which are increasing every year.

In the year 1900, there were around three million people in the United States over age sixty-five [2, p.1]. Today there are about thirty-two million Americans over sixty-five, and that number is growing rapidly [21, p.1]. The large number of babies born prior to World War II are now becoming a part of the elderly population. However, the largest number of babies was born during the "baby boom" era from 1945 to 1967 [17, p.8]. These seventy-four million people are approaching middle age and will start to retire between 2010 and 2030 [33, p.8]. Therefore, many have predicted that the number of Americans over age sixty-five will more than double to 65.6 million by the year 2030 [5, p.2], (See Appendix 1).

A factor involved with the rising percentage of older Americans is the declining fertility rate. The number of babies born was halved during 1800 to 1910 and was halved again from 1910 to 1980. Although the fertility rates went up significantly during the baby boom period after World War II, the rates have been declining since 1960 [17, p.7]. This time period has been called the "baby bust" because of the small number of babies born since the rates began declining [17, p.11], (See Appendix 2).

Because of the growing amount of older Americans as well as the decreasing

amount of younger Americans, the percentage of elderly in the United States is on the rise. The three million people over age sixty-five in 1900 represented about 4% of the population. Today the number of Americans over age sixty-five represents almost 13% of the total population. The projected numbers of older Americans show that by the year 2030, the elderly could be almost 22% of the American population [17, p.11], (See Appendix 3).

Increases in medical knowledge have been improving life expectancy for centuries. From the seventeenth century through the mid-nineteenth century, there were small increases in life expectancy because of improvements in nutrition, sanitation, and general living conditions. Then in the late nineteenth century through the mid-twentieth century, preventative medicine became the key to the increases in life expectancies. Vaccinations and anti-bodies were discovered and used to fight viral and infectious diseases. However, the greatest increases in life expectancies have occurred since the mid-twentieth century. These increases have resulted from new surgical techniques, organ transplants, CAT scans, chemotherapy, treatment of heart disease, improved rehabilitation, improved prenatal care and delivery, improvements in nutrition and exercise, reductions in smoking, as well as a growing awareness of environmental pollutants, food safety, automobile deaths, AIDS, poor medical care, drugs, alcohol, smoking, cholesterol, lack of exercise, and many more [10, p.107]. Life expectancies have changed a great deal. In 1900, the average life expectancy at birth was 41.4 for males and 49.0 for females. By 1985, these life expectancies had grown to 69.9 for males and 77.5 for females. If mortality improvements continue this way, life expectancy at birth will be 75 for males and 82 for females by the year 2000 [26, p. 47-48], (See Appendix 4). In analyzing the changes in life expectancies during this century, it is amazing to imagine how high the life expectancy might become in the future. How the mortality trends change in the future

will depend upon many things, such as new medical techniques, new medications, improvements in health and fitness, as well as new diseases and the changes in rates of violent crimes, smoking, and drug or alcohol abuse. The Census Bureau made projections of the number of older Americans based on mortality trends in the past. In the 1950's and 1960's, the mortality rates were fairly stable. The rates fell in the 1970's fairly rapidly, and again fell in the 1980's, but more slowly. Using the slowly declining projected mortality rates, as in the 1980's, the Bureau predicts that there will be 105 million Americans over age fifty by the year 2020. Using the rapidly declining projected rates, as in the 1970's, the Bureau predicts 121 million people over age fifty in America by the year 2020 [14, p.32-33]. Although the difference between these two projections may seem large, the fact remains that both projections predict great increases in the numbers of older Americans in the near future.

Although medical progress has increased life expectancy, it has changed the leading cause of death from infectious diseases to chronic diseases and illnesses. Each medical breakthrough "stalls death a little longer," [14, p.32]. Americans are living longer but not necessarily healthier lives. Therefore, the falling mortality rates and the increases in the elderly population will result in an increase in the need for long term care.

In the past, and even today, most of the long term care-givers for the elderly have been relatives, generally women. The American Association of Homes for the Aging states that only 20% of the elderly with long term care needs, live in a nursing home facility that would provide such long term care services [4, p.1]. This means that the other 80% of these elderly requiring care are living in the community and are receiving care from informal sources, such as relatives. However, this figure is expected to change. Many have predicted that about 40% to 50% of all Americans over age sixty-five will spend at least some time in a nursing home before death [19,

p.2]. Nursing home use is on the rise partly because of the increasing amount of elderly and the decreasing amount of young people available to provide care; but also, because of the changing family structure. Marriage and fertility rates are decreasing, and divorce rates are increasing; thus more and more elderly seem to have fewer family members as potential care-givers [27, p.24]. Also, women have been moving into the work force more frequently and staying there longer. One study stated that 29.9% of women worked outside the home in 1940; and by 1985, 73.3% of all women were working [17, p.242]. Since women have been a large source of informal care-givers in the past, their increased absences will leave the elderly with no choice but to seek care in a nursing home facility. In addition, sometimes relatives are unable to care for their elders because of distance. America's increasingly mobile society and the breakup of the traditional family structure often separates parents, grandparents, and children by hundreds of miles [13, p.2]. One other factor contributing to the increased nursing home use is that although the average life expectancy is around 75, many people are living into their 80's and 90's. These people often require a great deal of care. Although they may have children, these older people are often unable to receive care from their children because their children may already be over 60 and requiring long term care themselves [4, p.2].

The predicted increases in nursing home use has prompted much research on long term care. In an attempt to determine the causes of nursing home placement, several studies have been done on the types of people presently in nursing homes. These studies have shown that the risk of institutionalization depends upon many factors. The number one factor is advanced age. Physical and mental health tends to deteriorate rapidly around age eighty [26, p.55]. Most older people have at least one chronic condition, which requires long term care. The 1977 National Nursing Home Survey found that the most frequent chronic conditions were arteriosclerosis (found in

48% of the elderly), heart trouble (38%), senility (32%), arthritis and rheumatism (25%), hypertension (21%), and diabetes (15%). In addition, older people were two times as likely to have arthritis, visual and hearing impairments, and arteriosclerosis than those under 65 [17, p.54]. Mental deterioration also increases with age. In 1985, 63% of elderly nursing home residents were disoriented or mentally impaired enough to require assistance in every day activities. The American Association of Homes for the Aging found that about 45% of the people in nursing homes are 85 and over, about 39% are 74-85, and about 16% are 65-74 [4, p.1]. These statistics confirm the obvious: the older a person becomes, the more likely that person will need long term care services and the more likely he or she will be placed in a nursing home.

Marital status is also a key factor in the risk of nursing home use. In 1985, around 64% of all nursing home residents were widowed; and an additional 20% were either never married or divorced [17, p.46-48]. This is because it has been found that those who are married are less likely to have difficulty with every day activities and are thus less likely to need long term care services. In addition, even if one spouse were to have difficulties, the other would be there to provide assistance. Living alone greatly increases the need for outside help when chronic conditions appear, and thus increases the risk of institutionalization.

Another factor contributing to the risk of institutionalization is sex. One study states that the risk of institutionalization is twice as likely for women than for men and that women also tend to stay longer than men once placed in a nursing home [36, p.65]. The American Association of Homes for the Aging says about 75% of all nursing home residents are women [4, p.1]. One of the reasons women are more likely to use a nursing home is because women have a higher life expectancy than men. Many older women are outliving their husbands and are thus left alone, which, as already stated, is another factor contributing to institutionalization. Although this may be the

main reason, many say that women not only live longer than men, but they are also more likely to be disabled [10, p.1].

Race is an additional factor contributing to nursing home use. Around 93% of all nursing home residents are white [17, p.46]. This does not necessarily mean that other races have better health. In fact, black people have higher levels of chronic disability than white people [28, p.1]. Some people believe that many of the black people in the United States have more extensive social systems and much closer families. Therefore, they are more likely to receive needed care at home. Many other races in the United States tend to be poorer than whites, and often cannot afford care in a nursing home. Regardless of the reasons, white people substantially outnumbered all other races in the nursing homes of America, and this fact is not expected to change [4, p.2].

These factors were determined to be the key predictors in nursing home use. Many say the average, or typical, nursing home resident is an 80-year old white, widowed woman with several chronic conditions who has been in a nursing home for about a year and a half [4, p.1]. Although these factors have labeled many older people as "high risk," not all of the people labeled "high risk" belong in a nursing home; and not all of the people requiring nursing home care can be labeled "high risk" according to those factors. Therefore, a "system" was developed and has been used to "measure" the need for long term care. This "system" refers to the need for assistance in the Activities of Daily Living (ADL's). The Activities of Daily Living are generally considered to be bathing, dressing, toileting, transferring (from bed to chair), incontinence, and eating, although others have been listed as well. "ADL's can describe the presence and severity" of functional disabilities or limitations from physical or cognitive (mental) impairment and has been the most widely used measure of such limitations [36, p.90].

Many elderly require assistance with at least one of these Activities of Daily Living. The more limitations they experience, the more likely they will require long term care. This chart, which was developed by the American Association of Homes for the Aging, describes the most frequently experienced limitations in ADL's by nursing home residents [4, p.2].

<u>Activity</u>	<u>65-74 years</u>	<u>75-84 years</u>	<u>85+ years</u>
Bathing	85%	90%	94%
Dressing	70	76	82
Toileting	57	60	68
Transferring (bed to chair)	52	60	69
Incontinence	42	55	58
Eating	33	39	44

American Association of Homes for the Aging (1989)

Bathing is the most common limitation partly because it requires both upper and lower body strength as well as a great deal of balance. It is also the most common because of fear. Many elderly people are afraid they will fall while getting in and out of the tub and are therefore less inclined to try. The second most common limitation is dressing because it requires "small motor coordination" (finger use) and bending over. Arthritis is a very common problem for elderly people, and they often have trouble buttoning clothes or tying shoes. Toileting, or using the toilet, requires a great deal of leg strength and balance, as does transferring from a bed to a chair. Both of these activities can be difficult for an older person. Incontinence is the inability to recognize the need to use the restroom. This is a common ADL because this limitation is partly physical and partly mental. Eating is also one of the most common ADL's and is a problem for older people because it requires a great deal of coordination. Eating can also be considered a limitation for those who require tube-feeding, since they cannot

feed themselves [17, p.90-91].

Many times the need for assistance in several of the Activities of Daily Living can be reduced by the use of a cane, wheelchair, walker, or other mechanical aid. However, as the elderly grow older, they will often develop more and more limitations and will thus require more and more care.

The growing elderly population and the increased need for long term care have caused great concern in our country over the future of long term care services. Today there are over 1.5 million Americans in nursing homes, which is about 5% of the over-65 age group. There are also an additional six million elderly Americans who need assistance from family and friends to stay at home [3, p.1]. This means there are about 7.5 million Americans that need long term care services usually because of disabling chronic conditions. This figure is expected to grow to nine million by the year 2000 and nineteen million by the year 2040 [19, p.2], [18, p.5].

Although the number of people requiring long term care is on the rise, the cost of long term care is rising just as quickly, if not more so. Today, nursing home costs range from \$20,000 to \$80,000 a year, and average about \$25,000 to \$30,000 a year [20, p.40], [25, p.1]. Assuming an annual inflation rate of 5%, the average nursing home cost could be \$50,000 per year by the year 2000 [25, p.1]. However, this figure could become even higher because nursing home costs are rising even faster than inflation [20, p.40]. In fact, the cost of health care is rising more than any other segment of the economy [29, p.1]. In 1990, around \$43 billion was spent on nursing home care and around \$8 billion was spent on home health care. This means a total of more than \$50 billion was spent on long term care in one year [11, p.9]. Because of the rising health care costs, the Congressional Budget Office believes the annual long term care costs could increase between 50% and 200% by the year 2000 [19, p.6]. Many are concerned about how the increasingly large number of people requiring

long term care are going to receive care, and who is going to pay for the rising cost of their care. Currently long term care is financed mainly through the individual and Medicaid. The individuals receiving care and their families are paying about 51% of the total long term care costs. Medicaid, the federal welfare program which pays health care costs for poor elderly, covers around 42% of the long term care costs. Medicare, the federal social insurance program for the elderly, pays about 2% of the costs. Private long term care insurance covers around 1% of the total costs [32, p.2]. The remaining 4% is funded by a variety of other public and private sources such as Veterans Administration, Title XX of the Social Security Act, Supplemental Security Income, Older Americans Act, life care communities, and social HMO's [36, p. 37-40].

This current means of financing long term care is satisfactory for the very rich, who can pay for long term care themselves, and for the very poor, who qualify for Medicaid [11, p.3]. However, the remaining 70% of the population have to make some difficult decisions concerning long term care [25, p.1]. These middle-income elderly must either pay out-of-pocket and "spend down" to Medicaid level, have family members care for them, or go without care [11, p.3]. A better alternative could be Long Term Care Insurance.

IV. Long Term Care Insurance

Long term care insurance began in the mid 1970's with a few companies offering individual policies. During the first ten years, there were two distinguishing features of the long term care policies. These early policies paid for only skilled-nursing care and for care needed in a nursing home after at least a three day hospital stay. By 1985, these policies had changed little; and only a dozen or so companies had entered the long term care market. There were around 15 companies selling long term care insurance and a little over 100,000 policies in force [29, p.1]. However, in 1985, Aetna Insurance Company took a leap into the market and designed its own improved version of long term care insurance. They dropped the prior three-day hospital requirement and added coverage for custodial care. They also made the policies guaranteed renewable and included home health care coverage. This prompted other insurance companies to investigate the long term care market; and long term care insurance coverage changes, as well as market growth, exploded. From 1985 to 1990, more than 100 companies entered the long term care insurance business; and the number of in-force policies rose to over 1 million [12, p.14]. Although long term care insurance is still relatively new, it has experienced tremendous growth. In fact, long term care insurance is probably the fastest growing segment of the insurance industry [15, p.105].

Today there are around 135 companies selling long term care insurance and about 1.65 million policies in force [23], [9, p.16]. Although this figure is much higher than it used to be, it is still only 5% of all the elderly in the United States. Many are predicting that by the turn of the century, 25% to 40% of all elderly Americans will own long term care policies [25, p.1]. Some studies have predicted that there will be over 20 million policy-holders by the year 2000, and over 50 million policy-holders by the year 2020 [12, p.16], (See Appendix 5).

Current long term care policies can be placed into four main categories; individual, group associations, employer-sponsored, and provisions in life insurance. In the past, individual and group association policies have been the biggest markets and have sustained fairly steady growth in the past three years. However, employer-sponsored plans, as well as coverage through life insurance plans, have been growing fairly quickly in recent years [35, p.4]. In 1990, the Health Insurance Association reported that of the current 1.65 million long term care policies, around 77% were sold through the individual market, 17% were through group associations, 5% through employer-sponsored plans, and 1% as coverage with life insurance policies [9, p.16].

Individual long term care policies are the most common because those are primarily the types of policies that are available to potential customers. Group association policies, employer-sponsored plans, and life insurance provisions are the newest long term care ideas and have not been as fully developed as individual policies. Not as many companies have ventured into these other areas yet; and although these areas are growing, such policies are not as readily available to the public.

Current individual policies are usually offered to people between the ages of 50 and 84. Some companies will not sell to anyone over 79; and others will sell to people up to age 89 [35, p.14-15]. However, companies today rarely sell to customers below 50 or over 90. The average age of the individual policyholders today is 72, but that number will more than likely decrease as a result of the growing awareness of long term care needs. [35, p.10] These individual policies usually cover skilled, intermediate, and custodial care through a licensed nursing home; and many cover home health care and even adult day care that is provided by properly licensed facilities [1, p.27]. Eligibility for payments is usually determined by a physician's

statement of necessary medical care, or more often, his analysis of the insured's ability to perform the Activities of Daily Living. Many insurance companies generally state that if a person requires nursing home care because he or she is unable to perform a certain number of the ADL's listed on the policy, then the insured can begin receiving benefits. Each company can choose which of the generally accepted ADL's, such as bathing or dressing, will be written in the long term care policy and then state that payments will be made once an insured fails 2 out of 5 ADL's, 3 out of 6 ADL's, or some other such formula. This system has worked fairly well so far, and most policies have adopted the use of ADL's in determining eligibility for payment [35, p.12-13].

Most policies also allow a diagnosis of some type of cognitive (or mental) impairment to trigger benefits; because although these people require care, many can perform most of the Activities of Daily Living [30, p.98]. Older long term care policies generally required a three-day hospital stay prior to entering a nursing home, as proof that the insured really needed care, before benefits were paid. Very few policies still have this requirement because most people who go into a nursing home come directly from their own homes. This is because very few people need skilled-care, which is intense care generally needed after a hospital stay, for very long. Most older people enter nursing homes because of their inability to care for themselves, and ADL's are better at determining the need for this type of custodial care [7, p.7]. Numerous studies have shown that ADL's are significant predictors in the need for care [35, p.12].

Individual policies are generally indemnity policies, which means the insurance company will pay a fixed dollar amount each day the insured is in a nursing home. This fixed dollar amount can range between \$10 per day to \$120 per day [17, p.200]. However, the current average is about \$70 to \$80 per day, which is about \$25,000 to \$30,000 a year. Most policies also cover home health care, but the daily benefit is

usually 50% of the daily benefit for nursing home care. These policies usually limit the benefits to a maximum dollar amount or a maximum number of days or years. Most use a maximum number of years and often give the insured a choice between 2, 3, 4, 5, 10 years, or even lifetime coverage for nursing home care, and generally less for home health care. Sometimes policies allow the maximum benefit to apply to each "period of confinement," which means that if an insured were to stay in a nursing home for a five-year period and then return home, the policy would also cover a new period of confinement, even though the first five-year benefit had expired. However, in order for the new stay to qualify as a second period of confinement, the two stays must usually be separated by a given amount of time, such as six months [1, p.28].

Deductibles or elimination periods are another important feature of long term care policies. A deductible period is the length of time a policy-holder must wait, once a nursing home stay begins, before he or she can begin receiving benefits. Most policies have deductibles ranging from 0 to 365 days [35, p.16]. Typically, policies have deductibles of 0, 30, 60, 90, or 100 days; and the longer the waiting period, the less expensive the policy [7, p.10-11]. Most long term care policies today are also guaranteed renewable, which means that coverage cannot be canceled by the insurance company unless the insured fails to pay premiums or lies about his or her health on the application. It also means that premiums cannot be increased based on age or health. An insurance company can only raise premiums if it does so to an entire block of policyholders. Many policies also include a waiver of premium feature which allows the insured to stop paying premiums while he or she is receiving benefits. However, many times the policy states that this provision takes effect only after a certain amount of time in the nursing home, such as 90 days [1, p.28].

Most policies also have a six-month pre-existing condition (PEC) clause which states that the policy will not cover care related to health problems the insured had

when he or she purchased the policy. Therefore, companies often deny coverage for claims submitted within six months after the purchase date [1, p.27]. Insurance companies can also deny coverage for care needed for several other conditions as well. Insurers, in general, do not cover nursing home care or home health care for mental or nervous disorders. However, almost all companies cover Alzheimer's disease; and many also cover Parkinson's disease and senility. Care for alcoholism and drug addiction is usually another exclusion. Insurers generally do not cover illnesses caused by an act of war or treatment already paid for by the government. Usually, any "intentional, self-inflicted injury" or attempted suicide is excluded as well [7, p.9]. These exclusions are all fairly typical.

There are many other features of long term care policies that are sometimes included with the policy, but more often can be purchased as a rider to the policy for an additional premium. One very important feature is called inflation protection. This is usually a rider and is especially important to younger buyers. Inflation protection offers a certain amount of benefit increase every year, to insure against rising inflation costs. A person may buy a \$70 per day policy at age 50; however, when that person requires care around age 80, the care may cost \$150 per day or more. Unless that policyholder had purchased inflation protection, which would have increased the benefit, the original \$70 per day would certainly not be enough [6, p. 429]. Another feature often included as a rider is spousal discounts. Many times an insurer may offer discounts of 15% or more for couples jointly applying for long term care policies. This is partly because living alone is a major factor in determining the need for care, and spouses who live together can often provide care for each other. This discount is available also because many studies have shown that married couples tend to live healthier, happier lives and will less likely need care [30, p.98].

Many policies also have nonforfeiture benefits such as reduced paid-up

insurance, which provides the policyholder with a defined percentage of reduced benefit if he or she decides to stop paying premiums after a certain number of years. Another type of nonforfeiture benefit is a return of premium option, in which the policyholder would receive a certain percent of the premiums if he or she died or terminated the policy after a certain number of years. In general, the longer the policy is in force, the larger the percentage of benefit that applies to both of these types of nonforfeiture benefits [35, p.20].

Premiums for individual long term care policies are directly affected by age, daily benefit, maximum number of years, and deductible period. A long term care policy with an \$80 per day nursing home benefit, a four-year maximum, and a 20-day deductible issued to someone age 50, averages about \$480 a year. At age 65, the same policy would cost \$1135 annually; and at age 79, the premium would average up to \$3840 per year. Adding an inflation protection feature would raise the annual average premium to \$660 for someone at age 50, \$1400 at age 65, and \$4200 at age 79 [1, p.27].

Although individual policies are very popular right now, long term care insurance can also be obtained through a number of group associations. An example of such an organization is the American Association of Retired Persons (AARP). "AARP is the nation's leading organization for people age 50 or over," [5, p.15]. The organization lobbies in Congress, does research, and provides information and services all over the country [5, p.15]. A couple of years ago, the AARP began offering a long term care policy, which was supplied by an insurance company, to all of its members. This policy was given to every member who was willing to pay the premium. Many other such organizations offer long term care to their members through group association policies. In general, these policies contain the same features and benefits as most individual policies; however, not as many of these types

of policies have been purchased, partly because the number of consumers is limited to members of such groups.

Long term care can also be purchased through employer-sponsored plans. Although these types of policies have only been around since 1987, about 80,000 policies have been sold as of June, 1990 [35, p.5]. Employer-sponsored long term care is long term care insurance offered as a part of an employee's benefit package. Although the employee usually pays for the coverage, an increasing number of employers are contributing to the premiums for this long term care benefit. About 1%-37%, with an average of 5%, of all employees with the option to purchase, elect to buy the long term care coverage as a part of their benefit package [9, p.14]. These types of policies generally have the same features as individual policies, but there are a few differences. Many times, employer-sponsored plans have a maximum dollar amount rather than a maximum number of years. The average maximum dollar amount usually lasts about four to five years for nursing home care, eight to ten years for home health care, and somewhere in between for a combination of both [35, p.19-20]. Another difference is the issuing age. Employer-sponsored plans can have policyholders ranging from age 20 to age 90, because employers will usually offer these benefits to all of their employees. The cost is also a difference between individual policies and employer-sponsored plans. For an \$80 per day, 90-day deductible, 5-year maximum employer-sponsored policy, the average annual premium for someone age 30 is \$125. The average annual premium for someone age 40 is about \$176, for age 50 is \$320, age 65 is \$1158, and for ages 79-80 averages about \$4438 [35, p.20-21].

Long term care as a benefit with life insurance, sometimes called living benefits, is another increasingly popular method of insuring against the costs of long term care. This type of coverage is usually a rider attached to a life insurance policy. The rider

allows the policyholder to access part of the life insurance values, usually 2% of the face amount, to cover long-term care expenses. Many policies offer this living benefit as a rider to the life insurance policy with an additional premium. Other policies have riders that use the life insurance policy cash values to pay benefits and simply reduce the amount of the life insurance policy [9, p.25]. When the long term care benefits are paid this way, the coverage usually ends when 50% of the original face amount has been used [35, p.8]. These type of policies have really only been available since 1989, and as of June, 1990, around 14,000 policies with this living benefits rider had already been sold [35, p.5].

Many people are anticipating large growth rates in employer-sponsored plans and life insurance riders because of a predicted consumer trend towards these types of policies. These plans have great potential for many reasons. The first is that employer-sponsored plans and living benefits plans are able to reach a much wider age range than individual plans or even group association plans. Many younger people include a long term care benefit in their employee benefit package, and many will also add a long term care rider to their life insurance policy. Most insurance companies will not even offer an individual policy to anyone under 50. The average age of people buying employer-sponsored plans and life insurance riders is 43 and 48, respectively, as compared with 69 for group association plans and 72 for individual plans [35, p.7]. Another reason for the potential in these newer types of policies is cost. Employer-sponsored plans and life insurance riders will cost less on the average because younger people are buying these policies and the premiums are less expensive at younger ages. The cost is also reduced as a result of the decreased "adverse selection" that occurs when the coverage is offered to a large group of younger people. Some believe that employer-sponsored plans will also be less expensive because the employee can rely on the employer to find the best possible

plan at the lowest price. Also, premiums can often be paid as payroll deductions, which saves on taxes.

Although it seems that all long term care policies are similar, many are very different. There are no standard definitions for skilled care, intermediate care, custodial care, or any of the Activities of Daily Living. This means that all companies can define these terms any way they choose. For example, one company may have a policy that defines the ADL, eating, as "the ability to feed oneself, without assistance." Another company may have a policy that defines eating as "the ability to feed oneself, with or without the assistance of a tube." In the first policy, a tube-fed insured would fail this ADL and could possibly receive benefits. However, in the second policy, the insured would not fail this ADL and may not receive any benefits [30, p.33]. Such differences have caused slow progress in long term care insurance development as well as a great deal of misunderstandings between the insurance company and the customer. In 1986, The National Association of Insurance Commissioners (NAIC), very thoroughly discussed the lack of uniformity in the various states' policies and regulations. To balance the needs of the insurance industry and the consumers, the NAIC developed a Long Term Care Insurance Model Act and a Model Regulation. These have been reviewed and revised every six months since their introduction. Although the Model Act and Regulation are not required, they are recommended for all of the states; and as of April, 1991, 43 of the United States had adopted some version of the Model Act or Regulation [34, p.9]. The Model Act and Regulation have reduced some of the policies' problems, but there are still many problems in the marketing of long term care products.

The marketing problems are caused mostly by the lack of consumer demand, but also by the regulation problems and the bad press coverage. The lack of consumer demand is partly because of the lack of consumer awareness. Many people

do not know that long term care insurance is available to cover the risk of needing such services. Many older people do not even consider the need for this insurance because they believe they are covered by Medicare or Medicare Supplement. Medicare only covers expenses for acute, or short term, care and therefore, usually only pays for skilled care needed for rehabilitative purposes. Medicare Supplement does not cover any long term care needs [12, p.12]. The types of care needed most, custodial care and home health care, are not covered under Medicare and Medicare Supplement at all. Some people simply deny the risk of institutionalization and the need for long term care insurance because they are afraid to admit they may eventually need care [36, p.42].

Although the lack of consumer demand is mainly caused by the lack of consumer awareness, this low demand is also caused by the high prices of the policies. One reason for the high prices is that the actuarial data on long term care is very incomplete. There has been little actuarial literature, and almost no published actuarial experience available on long term care [27, p.20]. This lack of data makes it very difficult for insurance companies to accurately price long term care policies. It is difficult to predict future claims on long term care insurance when there is very little past claims experience available to analyze [12, p.18]. Therefore, many companies price these products higher to allow more room for variability in the claims without losing money. The premiums for long term care are high also because the possibility for adverse selection is strong. Adverse selection means those who buy the policies are usually the ones that need it. This makes underwriting more difficult and makes the premiums higher because claims are more likely. Another reason for the high prices is that the probability of moral hazard is high. A moral hazard is when an insured opts for increased care or higher quality care simply because he or she is covered by insurance [17, p. 209-210].

The marketing problems of the long term care products are also caused by the ineffective and non-uniform state regulations. These varied regulations add to the product development costs, and make further product development and improvements difficult [24, p.7]. Some have said that long term care insurance is one of the most regulated insurance products on the market, yet no one has determined exactly how to regulate it [34, p.11]. The NAIC has tried to create some uniformity in the state regulations with the Model Act and Regulation, partly to keep the federal government from taking over the regulations. Although the Model Act and Model Regulation have not solved all of the problems, they have apparently satisfied many needs because the federal government has not really become involved. Currently, there are over 150 bills in Congress on long term care, but none of them have been passed [12, p.16].

The marketing of long term care insurance has also been difficult because of the bad press coverage on faltering insurance companies as well as long term care insurance abuses. The current scare about many insurance companies' lack of financial stability has discouraged many people from buying insurance. From 1989 through 1990, around 73 life and health insurance companies were declared insolvent, including some highly rated companies. There have been several more insolvencies since then, and most likely more to come in the future [6, p. 432].

There has been a great deal of press coverage on the many abuses of long term care insurance. According to a California insurance consultant, "The number of customer complaints is very high for such a new business," [31, p.77]. One of the biggest complaints is agent abuse, including misrepresentations and scare tactics. Misrepresentation of benefits at the point of sale is the most common abuse. Many elderly people are misled about their coverage by agents who either lack the knowledge to clearly explain the benefits and exclusions, or were desperate to make a sale [16, p. 29]. Many agents use scare tactics in an attempt to convince elderly

people to buy long term care insurance. These agents tell their potential customers stories about other people who did not buy the insurance and the terrible things that happened to those uninsured people. Currently there are no effective methods for decreasing agent abuses, "and these abuses tend, unfortunately, to be most prevalent in sales to the elderly," [24, p.7].

In addition to the agent abuses, the press has also covered many insurance company abuses such as: improper denial of claims or termination of policies, large premium increases, delays in paying refunds for canceled policies, overselling, pocketing of premiums, and post-claims underwriting [8, p.3], [16, p.29-30], [17, p.40]. One of the most common of these abuses is post-claims underwriting, which is analyzing the policyholder's health history only after a claim has been filed, and then finding a reason to deny benefits [16, p.29]. Another common abuse is pocketing of premiums because companies who do not include nonforfeiture benefits with their policies can simply "pocket" all the money received from a policyholder who canceled before any benefits were paid [8, p.3]. Large premium increases is another abuse. As stated, companies can only raise their rates for entire blocks of policies. However, since the long term care business is so new and the future is unpredictable; companies will more than likely increase their rates a great deal. In fact, some say, "The next five years will produce rate increases as a rule rather than the exception," [6, p.431].

Although there are many problems with long term care policies, with the marketing of such policies, and with the abuses of long term care insurers and agents, much is being done to correct these problems. The Society of Actuaries' "Task Force on Long Term Care Insurance" has been working diligently to accumulate actuarial data [12, p.18]. Federal and state regulations are constantly being refined to ensure the availability of top quality long term care policies, as well as reduce the amount of

abuse on such policies. Much is also being done to educate the elderly on the increasing risk of institutionalization as well as their need for financial protection [22, p.29].

V. Conclusion

Long term care has been a significant topic of discussion for several years. It has been established that the need for long term care is increasing, as is the cost of that care, and the number of people requiring such care. However, strong disagreements arise when people discuss the possible solutions.

Many people believe that a national health care program, including long term care, is the solution to the problem. This type of program would ensure that all people could receive the care they needed. Others feel that the federal government could not handle the financial responsibility of such a program, because it would increase the already enormous federal deficit, as well as hurt the taxpayers dearly. These people believe that long term care insurance is the solution to the problem [19, p.1]. Still others, such as the Health Insurance Association of America, believe that the federal government and the private insurers "must combine their efforts and knowledge to create a solution that will benefit most Americans," [19, p.22].

Although no solution has been agreed upon, the fact remains that long term care is a great concern, and it is growing. The already stated statistics show that the number of elderly people in this country could more than double in the next 40 years. These people will be living longer lives, and the costs of their increased need for care could double in the next ten years. Long term care is a great concern in our country today, and a solution is desperately needed.

VI. Appendices

Appendix 1: Projected Number of Person 65+: 1900 to 2030

American Association of Retired Persons, "A Profile of Older Americans: 1990," Washington D.C., 1990, p.2.

Appendix 2: Total Fertility Rate, 1940-1986

Friedland, Robert B., Facing the Costs of Long Term Care, an EBRI-ERF Policy Study, Employee Benefit Research Institute, Washington D.C., 1990, p.10.

Appendix 3: Older Americans in the Total Population, Actual and Projected, 1900-2080

Friedland, Robert B., Facing the Costs of Long Term Care, an EBRI-ERF Policy Study, Employee Benefit Research Institute, Washington D.C., 1990, p.12.

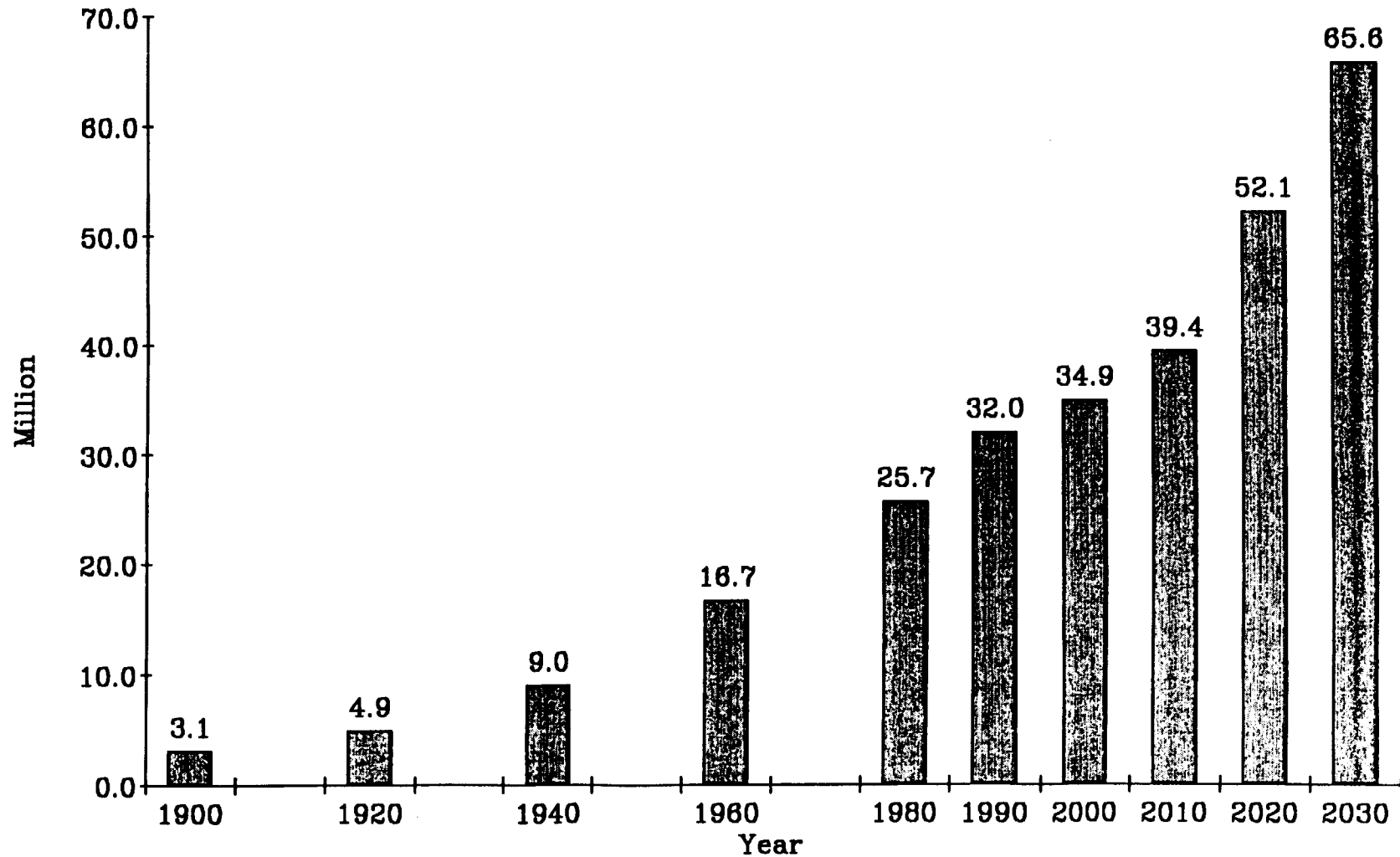
Appendix 4: Life Expectancy at Birth, Actual and Projected, 1900 to 2000

McLaughlin, Walter J., "Mortality Improvement: A Twentieth Century Phenomenon," Contingencies, November/December, 1990, p. 48-49.

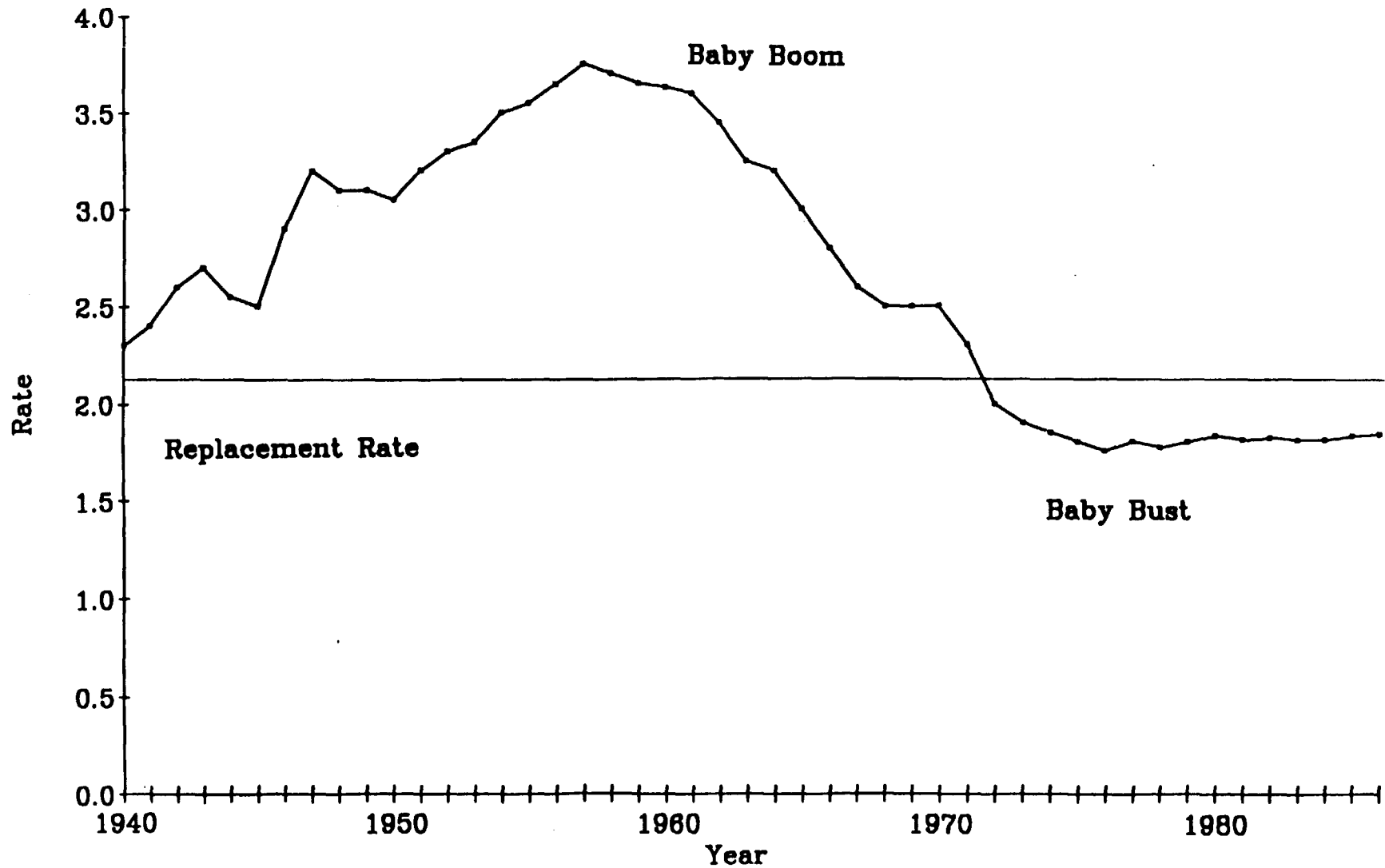
Appendix 5: Projected Long Term Care Policyholders

Corliss, FSA, Gary L., "The Evolution of Long Term Care Insurance," Resource, February, 1991, p. 16.

Projected Number of Persons 65+
1900 to 2030



Total Fertility Rate, 1940-1986



Appendix 3

Older Americans in the Total Population Actual and Projected, 1900 to 2080

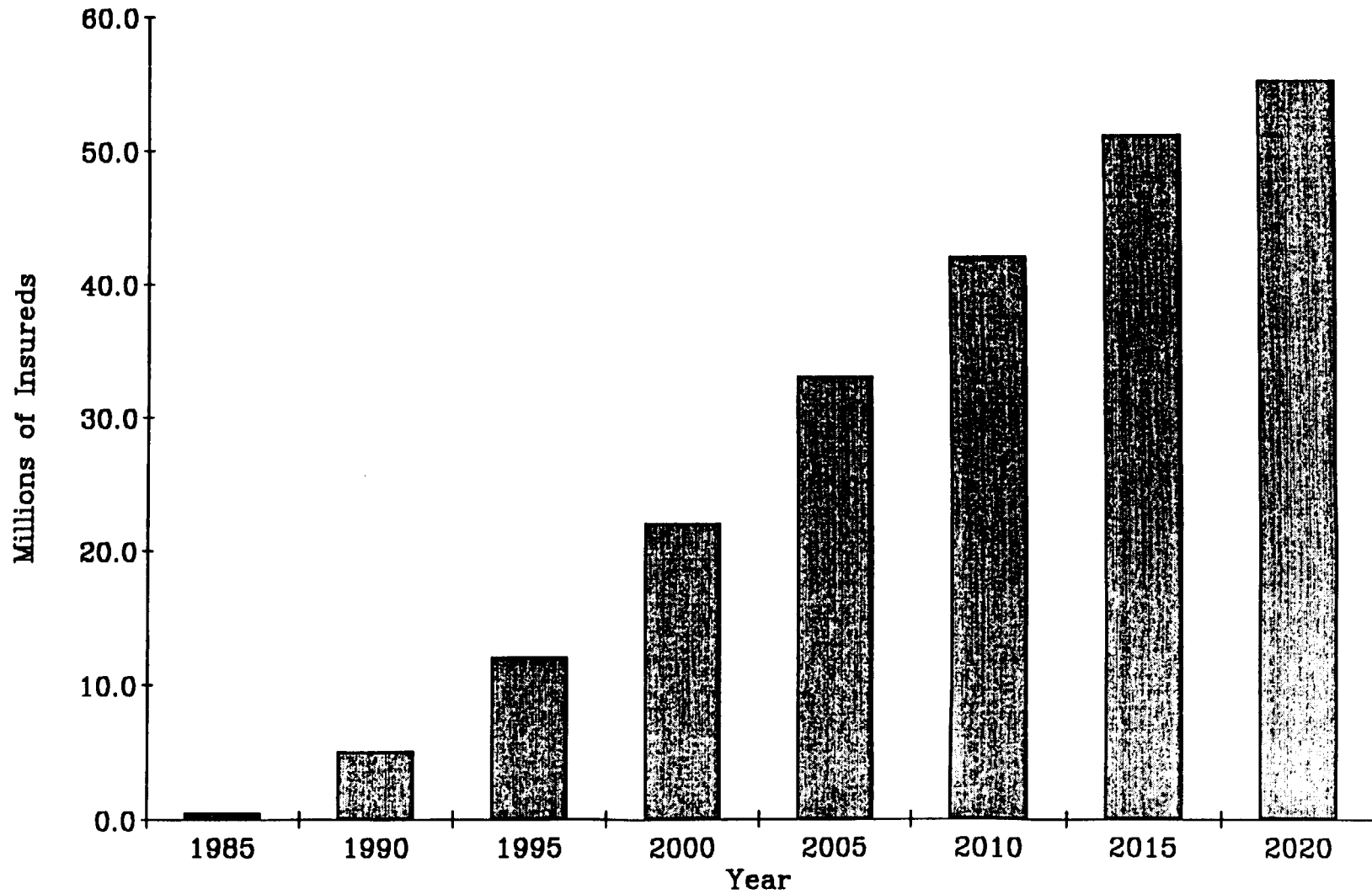
Year	Aged 65 or over		Aged 85 or over		Total Pop. in thousand
	Number in thousands	% of Total Population	Number in thousands	% of Total Population	
1900	3,084	4.0 %	123	0.2 %	76,303
1910	3,950	4.3	167	0.2	91,972
1920	4,933	4.7	210	0.2	105,711
1930	6,634	5.4	272	0.2	122,775
1940	9,019	6.8	365	0.3	131,669
1950	12,270	8.1	577	0.4	150,967
1960	16,675	9.2	940	0.5	180,671
1970	20,107	0.9	1,430	0.7	205,053
1980	25,704	11.3	2,269	1.0	227,758
1985	28,540	11.9	2,695	1.1	239,279
1987	29,835	12.2	2,867	1.2	243,913
1990	31,559	12.6	3,254	1.3	250,410
2000	34,882	13.0	4,622	1.7	268,267
2010	39,362	13.9	6,115	2.2	282,574
2020	52,067	17.7	6,651	2.3	294,364
2030	65,604	21.8	8,129	2.7	300,629
2040	68,109	22.6	12,251	4.1	301,807
2050	68,532	22.9	15,287	5.1	299,848
2080	71,631	24.5	16,966	5.8	292,235

Appendix 4

Life Expectancy at Birth
Actual and Projected, 1900 to 2000

Year	Males	Females
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1900	46.4	49.0
1910	50.1	53.6
1920	54.5	56.3
1930	58.0	61.3
1940	61.4	65.7
1950	65.6	71.1
1960	66.7	73.2
1970	67.1	74.9
1980	69.9	77.5
1990	73.4	80.8
2000	75.2	82.7

Projected Long Term Care Policyholders



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